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ABSTRACT

The purpose and approach of community mental health in the urban ghetto is discussed. Mental health service is viewed as an alien institution by the deprived citizen and institutions of the Kennedy era were naive the approaches from 1963 on were only new in ideals but not practice. Each center is meant to offer its community consultation and education, however, its personnel is untrained and citizenry resistance monumental. Furthermore, the cause of mental illness in the ghetto, its prevention and treatment have not been clearly identified. Most specialists at the centers do not know what their out-center neighborhood task is. The staff usually consists of young graduates in psychology assisted by nurses, aids and inexperienced workers. Thus group therapy, the single most important tool, can only be crudely adopted if at all. The author also discusses other side effects of untrained personnel. He notes that the suave treatment and approach used for the middle class is applied to the poor. Apathy and militancy of the community force the worker to deviate from his professionalism thus approaches which bring black and white together advocated. The author suggests that the centers be staffed by members of the neighborhood. (Author)

The Challenge of Ghetto Community Mental Health*

Hugh Mullan, M.D. **

Introduction:

In the United States, community mental health, both as a slogan and as a goal, seems to have caught on. But like many movements, its early excitement and hope fail to match its present practice and accomplishment. Particularly, in the urban ghetto where need is great, results have been negligible. This fact, ignored to some degree in mental health circles, should make clinicians and administrators carefully evaluate first their goals and then their practices. Long overdue is an objective examination of C.M.H. purposes and approaches. Two questions need answers: Can methods and ends of C.M.H. be applied to urban dwellers of the inner city? And can they be applied now?

On the community's side, the promise of mental health service which fails to materialize further upsets the already deprived citizen. He views the new mental health center as an alien institution but extremely powerful. He begins to covet its operation noting the job and career advancement possibilities. It is another part of the white establishment which he must take over.

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During Kennedy's term of office the planners for better mental health for the masses were variously motivated; some wished to grant the less fortunate the same opportunity for a stable emotional life that they received; some felt that society's ills would be reduced if the underprivileged functioned better psychologically; and some wished to implant their values on to the less fortunate thus altering them in a fundamental way. Regardless, the value of these intentions, now proven to be a somewhat naive and difficult, if not impossible to fulfill, federal policy and mandate in the area of C.M.H., reinforced by millions of dollars, started a change but in many instances not the one sought.

Since 1963 a C.M.H. mystique has developed. Its proponents describe "a bold new approach" which first aims to prevent mental illness; second, to insure the early recognition of the potential patient; and third,to treat him quickly and effectively when discovered. Yet, upon examination of a center seven years later, a center which is basic to this movement, almost nothing "new" in treatment method is disclosed. The usual departments and sub-divisions manned by the usual professionals who practice the usual therapies makes the center indistinguishable from the traditional psychiatric agency.

Before Federal assistance is forthcoming each center, in addition to the customary treatment and care programs, must offer its community "consultation and education". The mystique that surrounds community mental health is largely based upon this highly new concept. Much of the confusion, frustration and ineffectuality felt by the C.M.H. specialists

in urban centers stems from this demand for new service. To meet this request they must abandon their roles and expertise, physically leave the center and support the citizen so that he becomes more successful in his social, economic and political struggle. However, the methods and goals of Consultation and Education are obscure, the personnel responsible for this service untrained and inexperienced, and the resistance of the citizenry, monumental. In the center's attempt to reach the community to fulfill this mandate, innovations in the center system are introduced with telling result. Democratization of the staff with blurring of roles and status, on-the-job training of indigeneous workers, sharing mental health responsibility and leadership with the non-professional community leaders, and, social action all tend to remove the community mental health centers from the field of psychiatry, jeopardize its psychiatric function and make it an instrument for social change.

The Problem:

No fault is to be found in a grand scale mental health plan which calls for prevention, early recognition of emotional illness and proper treatment, all conducted in the patient's neighborhood. When viewed in this light the community mental health effort becomes a giant delivery system; a means to effectively enter each person's house, single out the maladjusted person and immediately set about to correct his aberration.

However, failure to take into consideration certain facts makes this far reaching plan, for the most part, inoperable. Mental illness on

a large scale, including social and cultural factors, has not been identified as to cause, method of prevention, and method of treatment. The human components of this projected vast mental health delivery service, the workers and their associates, are largely unavailable, and inadequately trained and experienced in extra center activities. Finally, the desires and the needs of the citizenry, their priorities for existence have been overlooked.

Who is the Patient; Citizen or Community?

The phrase "community mental health" implies the existence of a model, a neighborhood which boasts a citizenry free from psychopathology. If one were to be discovered would it indicate the presence of healthy persons or the presence of institutions supporting constructive values? Treatments offered in a center suggests that the focus is on the pathological citizen. Consultation and education on the other hand, so-called "out-reach" activities, point a finger at the neighborhood at large. This approach indicates that the fault lies in the homes, schools, churches, playgrounds and so forth whose existing modes of behavior produce conflicted and disturbed human beings. This confusion in identity and purpose plagues the C.M.H. center movement. Recently in a center, no consensus could be reached as to definition of community mental health, or community psychiatry. Seasoned mental health specialists of the three disciplines plus an anthropologist, statistician and nurse, in an extended series of meetings, could identify their in-center duties but failed to discover what their out-center, neighborhood professional task might be.

Who is the Community Mental Health Specialist?

We are told that over forty million persons are presently or in the near future to receive mental health services in their neighborhoods. Who will treat and counsel this multitude?

C.M.H. centers are staffed with the usual specialists; psychiatrists, psychologists, social workers, nurses and students of various kinds. Over worked and underpaid in many instances these workers are supplemented by the indigeneous employee and volunteer. The numbers and kinds of professionals are determined by budget and therefore do not necessarily reflect community need. Relatively few senior psychiatrists can be pursuaded to leave the practice or teaching of psychiatry for a career so peripheral to their interests and training and one so indefinite in purpose. Centers must depend, therefore, upon the young graduate in psychology and social work to perform all psychotherapies; individual, group, family, married couples, crisis intervention and so forth. Assisted by the nurse, nursing aid, practical nurse and the indigeneous worker these fundamental treatment methods become the shared responsibility of staff members many times ill equipped and untrained and in some instances, uneducated.

Group psychotherapy, for example, an established treatment form, has been crudely adopted, its principles violated as nursing aides and other employees some without high school diplomas conduct group sessions. Heralded as an innovation, indigeneous workers with neither psychological frame of reference nor goal lead groups of unselected patients suffering from illnesses ranging from schizophrenia to drug addiction.

While it is true that the group method of psychotherapy (and group therapy-related practices) is the single most important tool that the center possesses, to reach the disabled citizenry, the bastardization of this system is not the answer. A lecture given to a center staff on group psychotherapy practice was so foreign to the listeners that one commented, "We don't and never have done group therapy here". "I wonder what these countless groups are about".

Noxious side effects stem from the untrained person's leadership of patient groups: Roles of all mental health specialists become blurred, lines of authority are undercut, and the psychiatrist's responsibility for patient treatment and care is challenged. While it is true that a nursing aid because of his color, youth and "groovie" vernacular can easily establish a relationship with those of his own race it does not follow that this ability for instant rapport makes him equal to the psychiatrist. Much of the unrest, reorganization, status and race conflicts which now are emerging in urban, ghetto centers is based upon this faulty aggrandized position that some unskilled workers have assumed. Calling themselves "group therapists" they ask for equal say in policy decisions some of which effect not only the center's administration but as well its clinical program.

In addition some workers who live in the ghetto area served by the center tend to identify on racial grounds with the citizens. This sameness of out-look in the area of civil rights polarizes them against their superiors whom they see as part of the white establishment. They side with the community against their center when neighborhood groups ask for more control.

The Recalcitrant Recipient of Mental Health :

The ghetto community mental health movement is in serious trouble. The well meaning health planners of an affluent nation have encouraged mental health specialists to offer extended psychiatric services to the millions who live in the inner city. Laudable as this plan is, it fails to take into account the ethnic and racial characteristics of the ghetto inhabitant, his physical environment which perpetuates illness and his priorities of need.

U.S. psychiatry especially psychotherapy is largely a middle class phenomenon, - the practitioners and recipients both coming from this same segment. Treatment systems suitable to this section of America are not necessarily applicable to groups, racially and culturally, different and particularly when, in addition, these citizens are deprived, uneducated and unemployed. An exception to this is the physical treatment of the psychotic person. But in the psychotherapies, for a viable treatment form to exist, there must be some congruence between therapist and patient in mores, values, and in goals.

The poor of our cities, unlike the middle class citizen, rarely asks for psychotherapy. He views his problem as external, caused by factors over which he has no control. He points accusingly to the establishment, describing unfulfilled needs in housing, education, sanitation, transportation and physical health. Mental health fails to appear on his list of priorities.

To counteract this lack of motivation, C.M.H. programs urge workers to know their communities, leave the center and practice

their specialty in the neighbourhood. Under the rubric of Consultation and Education the mental health specialist finds herself in a neighborhood littered with broken bottles, rusting cans and discarded tires, with angry negroes standing at corner store fronts and with newspapers filled with gruesome accounts of assaults, robberies and rape. Under such circumstances this professional is well advised if she is accompanied by others and if one person is an indigenous male worker.

Citizens from the same block, grouped together to plan for garbage collection where none existed previously view with suspicion the presence of C.M.H. workers from the Center. What is their purpose and how can they help? Staff members in order to assist these persons must forgo their professionalism, respond emotionally to the plight of the underprivileged, become activist to participate openly and boldly in political maneuvers.

Although not as clear-cut, the same response from principal and teachers greets the C.M.H. psychologist in school consultation. If for example this specialist works in traditional fashion testing, treating, and disposing of sick children his efforts may be appreciated. But should he, on the other hand, offer "institutional" consultation indicating that the teaching and administration systems are injurious to the mental health of the students his efforts in all probability will be angrily rejected.

There is every indication that, for a long time to come, two societies viewing themselves differently, are to exist side by side. The militancy of the inner city dweller is his single means for extrication from conditions inimical to him and to his family. He must for a while reject middle class standards and customs including particularly psychotherapy. Any psychological approach which focuses upon the individual as responsible for his dilemma, which calls for self scrutiny and personal assessment, can not be used. There is some indication, on the other hand, that variants of the group psychotherapy method are helpful in mobilizing hidden group resources, defining essential tasks and offering methods to achieve desired social changes.

Group Therapy related approaches which bring white and black together regardless of agenda and goal are significant. C.M.H. Centers employing blacks and whites aid in acculturation. This is particularly true in those centers which encourage career advancement for the underprivileged. However, safeguards must be discovered and employed to prevent C.M.H. Center control from slipping into the hands of the non-psychiatrist or from being seized by non-professional community groups.

C.M.H. Centers to be truly of the community should be staffed by residents of the neighborhood. It will take time for indigenous workers to achieve education and experience in the fields of psychiatry, psychology and social work. Only when local residents are properly trained should Center operation be

turned over to them. Similar to the surgical hospital the C.M.H. Center must be an institution offering specific treatment for defined illness.